

THE
AMERICAN BOARD
OF
PLASTIC SURGERY
INC.

PART II EXAMINATION

MAY 1974

Name of candidate : Sami M. Mamoun , M.D.

A portfolio of 8 plastic surgery case reports submitted by Dr. Sami Mounir Mamoun, M.D. (7-16-1941 to 7-23-2024) to the American Board of Plastic Surgery, in 1974, as part of the candidate examination for consideration of gaining board certification in plastic surgery.

Statement

To The American Board of Plastic Surgery Inc.

I hereby certify that the planning and essential surgical procedures described herein were performed by me as an independent operator.

Sami M. Mamoun M.D.

Sami M. Mamoun, M.D.

1974

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Statement

Category listing of the eight case summaries

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- Case No. 5 : Malignancies or conditions prone to malignancy.
- Case No. 6 : Plastic surgery of the hand.
- Case No. 7 : Congenital anomalies.
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Sami M. Mamoun M.D.

Sami M. Mamoun , M.D.

The American Board Of Plastic Surgery Inc.

Part II Examination - May 1974

Candidate's name : Sami M. Mamoun , M.D.

Category Listing Of The Eight Case Summaries

1. Category One : Acute burns.

Case No. 1 :

Acute second and third degree flame burns of the lower extremities and left forearm .

2. Category Two : Facial bone fractures.

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Case No. 6 :

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Case No. 8 :

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Sami M. Mamoun M.D.

1. Category One : Acute burns.

Case No. 1 :

Acute second and third degree flame burns of the lower extremities and left forearm .

Case Summary

Candidate's name : Sami M. Mamoun, M.D.

Category One : Acute burns.

Case No. 1 :

Acute second and third degree flame burns of the lower extremities and left forearm.

This 43 year- old black female was admitted with acute 20% second and third degree flame burns of the lower extremities and left forearm. This happened accidentally at her home, when stove flames caught her clothes. The burnt areas involved the antero-lateral surface of the leg and thigh (right), and the antero-medial surface of the left leg and knee. Similarly, the dorsal region of the left forearm was also burnt. Moreover, the patient was in her fifth month of pregnancy, and she had a long history of left sided hemiparesis of unknown etiology.

On admission, the patient's general condition was satisfactory, and her vital signs were stable. She was given approximately 3000 cc of fluids I.V. daily for a period of two days, in addition to oral fluids. Systemic antibiotics were also administered.

Approximately 15% of the burn wounds of the lower extremities and left forearm were third degree burns, and these areas were covered by a thick leathery eschar. Local care of the burn wounds was started on admission, consisting of topical application of Betadine ointment (Povidone - Iodine), in the form of closed dressings, changed twice daily. Moreover, daily cleansing and debridement of the eschar in a Hubbard tank was performed.

After a period of approximately five weeks the burnt areas of the lower extremities (Figures 1&2), and of the left forearm (Fig. 3) were covered almost completely by a healthy looking granulation tissue, and were ready for skin grafting. Under general anaesthesia the rest of the eschar was debrided, and split thickness skin grafts were taken from the left thigh, using the Brown pneumatic dermatome, opened to .0015 inch. The skin grafts were next meshed, using the 1:3 expansion carriers, in order to limit the amount of skin grafts needed to cover all the burnt areas. The meshed skin grafts were transfixed in place over the layer of granulation tissue, using Steri-Strips (figs. 4, 5, & 6). Proper dressings, elastic bandages and posterior splints of Plaster of Paris were next applied.

Post operative course was smooth and uncomplicated. The skin grafts healed well (Figs. 7 & 8), and those on the lower extremities were constantly protected with elastic bandages. Patient was kept on bed rest and leg elevation for approximately two to three weeks postoperatively.

Sami M. Mamoun M.D.

OPERATIVE RECORD

660-2

7 Medical

LOCATION (OR ADDRESS)

036537

UNIT NUMBER

Preoperative Diagnosis Complete

Second & Third Degree Burns of
Lower Extremities & Left Upper
Extremity

CONDITION OF PATIENT

Temperature	Respiration	Pulse	Blood Pressure	General Condition

Anesthetic General

Condition during Anesthesia (Pulse, Respiration, Stimulants, etc.)

Operation See Below

Operation

Began 2:20 p.m. Closed 4:30 p.m.

Date 11/15/73

Doctor LoVerme

Postoperative Diagnosis

Same

Surgeon Dr. Mamoun/Dr. Lo Verme

Anesthetist Dr. Grogean/Dr. Joseph

Assistants Dr. Egtegar

Instrument Nurse Rojas/Battaglia/Openo

Sponge Nurse DeVries/Condo

~~Findings~~ Describe All Pathological Findings and All Organs Explored (Normal and Abnormal)

Operation:

1. Debridement of Burn Eschar of Both Lower Extremities and of left Forearm.
2. Split Thickness Skin Graft (Meshed) From Left & Right Thighs.
3. Posterior Plaster Splint to the Right Lower Extremity.

~~What Was Done~~

Findings:

About five weeks ago this 43 y.o. N/F was involved in an accidental second and third degree burns of the anterior surface of the lower extremities and the left upper extremity. The burns covered an area of approximately 20% of the body surface and about 15% of body surface was third degree burn. On admission the patient had a brownish-black thick eschar covering the burnt surfaces of the lower extremities and of the left upper extremity. The patient was placed on Betadine dressings, ^{changed} daily, in the Hubbard tank. Moreover, mechanical debridement was performed almost daily until eventually the majority of the eschar was debrided. Eventually, the patient developed a layer of healthy looking granulation tissue over the anterior surface of the lower extremities and the left forearm. The burn of the right lower extremity extended almost along the distal half of the anterior surface of the thigh, including the knee and almost the proximal two-thirds of the leg in the anterolateral surface. The deep burnt area over the left lower extremity included the anteromedial region, involving the margin of the left knee and just distal to it over an area of approximately 6" x 5". Today, debridement of the remaining eschar was performed and the ^{meshed} split thickness skin graft (using a mesher dermatome) was applied. The grafts were meshed using 1 to 3 ⁱⁿ extensions. The burnt area over the dorsal surface of the left forearm measured approximately 7 x 2" and this was also debrided of ^{the} eschar.

Immediate Postoperative Condition (Hemorrhage, Shock, etc.)

Dictated by: Dr. Mamoun

Signature of Operator

Transcriber: Karen Miller

Date Dictated: 11/15/73

Date Typed: 11/29/73

(CONTINUE ON REVERSE SIDE)

regions and a split thickness skin graft (also meshed) was applied. In addition to the burns, the patient was in her seventh month of pregnancy and preoperatively the patient refused to have spinal anesthesia and therefore we planned to perform the procedure under general anesthesia. Prior to surgery, two units of packed cells were given, since her hematocrit was found to be 28 with a low hemoglobin of 9.

Procedure:

Under general anesthesia and following preparation of both lower extremities and left upper extremity with Betadine and proper draping, the eschar covering small portions of the left and right lower extremities was debrided using a blade, scissors and knife techniques.

Since it appeared healthy + no granulation tissue as to
It was decided not to scrape any of the present granulation tissue, *since they appeared*
~~in order to~~ avoid excessive bleeding. The burnt area of the right leg covered approximately 40" x 6" over the anterolateral surface. Split thickness skin grafts were taken from the left and right thighs using the brown air dermatome and the thickness of 15,000ths of an inch was taken. The grafts were meshed in the ^{expansion carriers} mesher and applied. *Operation*
The edges of the grafts were held to the skin with a few pieces of steri-strips. Dressing of Betadine gauze and 4 x 8 gauze were applied and the posterior splint of plaster of paris was applied to the right leg maintaining the right knee in about 15 to 20° of flexion and the ankle in normal position. The patient tolerated the procedure well and was sent to the Recovery Room in general good health.

Sami Mamoun M.D.
Dr. Mamoun



Case No. 1 ; figs. 1 & 2 : Preoperative views of the burn wounds of the lower extremities , showing a layer of healthy-looking granulation tissue , with the minimal remaining eschar.



Case No. 1 ; fig. 3 : Preoperative appearance of the burn wound of the left forearm .



Case No. 1 ; fig. 4 : Operative view of the meshed split thickness skin grafts covering the burnt area of the left forearm .



Case No. 1 ; fig. 5 : The meshed skin grafts covering the burnt area of the left knee, and transfixed in place with steri-strips.



Case No. 1 ; fig. 6 : Five days postoperative appearance of the healing skin grafts , and of the donor sites of the lower extremities .



Case No. 1 ; figs. 7 & 8 : Three months postoperatively : The skin grafts and their donor sites healing well.

2. Category Two : Facial bone fractures .

Case No. 2 :

Displaced fracture of the right zygomatic bone .

Case Summary

Candidate's name : Sami M. Mamoun, M.D.

Category Two : Facial bone fracture.

Case No. 2 :

Displaced fracture of the right Zygoma.

This 60 year-old white male was admitted through the emergency room because of a severe trauma he sustained to the right side of his face , when he was mugged and hit by some person. The whole face was edematous, with severe ecchymosis of the right side of the face and neck. (Figs. 1 & 2). Moreover, he had a 2.5" transverse laceration of the right side of his forehead (which was sutured in the emergency room). Neurological examination was negative. He had no diplopia, and complained of only minimal pain on chewing. The right malar region clinically appeared depressed, and there was a step-deformity along the infraorbital ridge. The only teeth he had were the lower incisors and canines.

X-rays of the facial bones, including Water's view , zygomatic arches, and later, tomograms of the orbits , (figs. 3, 4, & 5) , revealed a displaced trimalar fracture of the right zygomatic bone and arch , but no fracture of the orbital floors. Moreover, there was a non displaced isolated fracture of the coronoid process of the vertical ramus of the right mandible.

Following one week of observation and bed rest , the facial swelling gradually subsided, and it was planned to perform open reduction and interosseous wire fixation of the displaced fracture of the right zygoma. Since the zygomatic arch fracture (fig. 4) was not depressed, we planned not to wire it, but only to elevate it if needed.

Through an infraorbital and a lateral eyebrow incisions (fig. 6) the zygomatico-maxillary and zygomatico-frontal fracture sites were identified . the step deformity , which was felt along the infraorbital ridge , was due to a 0.8 cm. depression and medial rotation of the zygoma. With the help of a bone jaw forceps, the zygoma was reduced to a proper alignment, and splinted in place with No. 25 interosseous wires, using the pneumatic burr hole drill. The latter fixation was performed at each of the zygomatico-maxillary and zygomatico-frontal fracture sites, and the skin incisions were next sutured. An epidermal inclusion cyst was also excised from the margin of the skin incision. As for the isolated , ~~non-displaced~~ fracture of the coronoid process , we decided that surgical intervention was unnecessary.

Post operative course was smooth and uncomplicated . Postoperative X-rays (Water's view) (fig. 8) revealed the site of the interosseous wires, and showed proper alignment of the right zygoma. The patient's appearance in the early postoperative period is shown in figures 9 & 10 .

Sami M. Mamoun, M.D.

LOCATION (OR ADDRESS)

UNIT NUMBER

Preoperative Diagnosis Complete
 Traumatic Displaced Fracture of Rt. Zygoma.
 Skin Lesion of the Rt. Lower Eyelid.

CONDITION OF PATIENT

Temperature	Respiration	Pulse	Blood Pressure	General Condition

Anesthetic General

Condition during Anesthesia (Pulse, Respiration, Stimulants, etc.)

Operation: 1. Open Reduction of Displaced Fracture
 of Rt. Zygoma.

2. Interosseous Wiring Fixation. 3. Excision

Began 12:00 Noon Closed 2:30 Eyelid.

Date 1/4/74

Doctor L. Reddy

Postoperative Diagnosis

Same

Surgeon Dr. Mamoun

Anesthetist Dr. Presbitero/Dr. Joseph

Assistants Dr. L. Reddy

Dr. K. Reddy

Dr. Zak

Instrument Nurse D. Norton

Sponge Nurse Selinski

Findings (Gross): Describe all Pathological Findings and All Organs Explored, Normal and Abnormal

About one week ago this 60 y. o. W/M was mugged and hit on the right side of his face thus sustaining a displaced fracture of his right zygoma, as well as a non-displaced fracture of the coronoid process of the vertical ramus of the right side of the mandible. The patient denied having diplopia and he had minimal pain on eating.

Clinically, the right malar region appeared to be depressed. Tomograms of the right orbit were obtained and these revealed no fracture in the floor of the right orbit.

Moreover, x-rays of the facial bones revealed the presence of the trimalar fracture and the above described fracture of the coronoid process of the right mandible. Today, namely eight days after the injury, when the swelling had subsided and the patient was more comfortable, open reduction was performed and interosseous wire fixation applied. The right zygoma was found to be displaced and rotated laterally. The fracture site along the infraorbital ridge was found to be separated and the medial portion of the fracture site was separated from the lateral portion and the zygoma was depressed approximately 0.8 cm. in that area.

OPERATIVE TECHNIQUE: Under general anesthesia and following preparation of the face with diluted Betadine soap and proper draping, two incisions were made each one approximately 1" in length; the first incision was outlined along the lateral region of the right eyebrow and the second incision was outlined with Methylene Blue along one of the transverse skin creases in the infraorbital region. The lateral incision was approximately $\frac{1}{2}$ cm. inferior to the eyelash margin. The skin incision was first made in the lateral region of the right eyebrow and the incision was deepened through the subcutaneous tissue and muscle down to the bone and through the periosteum overlying the fracture site. The periosteum was elevated off the fracture site on both the anterior and the medial region (the orbital surface) and the fracture site was completely visualized for 1 cm. on either side. Attention was next focused on exposing the infraorbital fracture site and the skin incision was deepened through the orbicularis oculi muscle and with the help of retractors, the periosteum overlying the fracture site in

Immediate Postoperative Condition (Hemorrhage, Shock, etc.)

(over)

Dictated by: Dr. Mamoun

Signature of Operator

Same Mamoun M.

Transcriber: Mary Geremia

Date dictated: 1/4/74

Date typed: 1/15/74

(CONTINUE ON REVERSE SIDE)

the infraorbital region was exposed. The periosteum was incised and the fracture site was exposed completely for a distance of approximately 1 cm. on either side. The periosteum was elevated off the floor of the orbit in an attempt to explore the lateral region. No depressed fractures were seen involving the floor of the orbit and no muscle entrapment could be visualized. Attention was next focused on reducing the depressed zygoma and then wiring it. With the help of the bone jaw forceps the zygoma was reduced and maintained in the proper position. Two drill holes were made, one on either side of each fracture line using the pneumatic drill hole instrument and interosseous wires were used (25 gauge stainless steel wire) and while maintaining the zygoma in the proper position and alignment, the wires were twisted firmly in place and cut short. The stump of the cut wire was curved along the bone surface. We had proper alignment and positioning of the zygoma at the end of the procedure. The area was irrigated thoroughly and the periosteum was closed with a few sutures of 4-0 chromic catgut and the skin edges were approximated with a few interrupted and simple and mattress sutures of 6-0 nylon. Dressings were applied. Patient tolerated the procedure satisfactorily and was sent to the Recovery Room in general good health.

Sami Mamoun
Dr. Mamoun

ADDENDUM: There was a skin lesion measuring approximately 0.8 x 0.5 cm. located along the lateral region of the right lower eyelid, approximately 2 cm. below the eyelash margin. The skin lesion was outlined with Methylene Blue as an extension of the original skin incision that was needed to expose the fracture along the infraorbital ridge region. The skin lesion was excised and the bleeders were ligated with #4-0 chromic catgut.

Sami Mamoun M.D.
Dr. Mamoun

DEPARTMENT OF RADIOLOGY JERSEY CITY MEDICAL CENTER

149815

16 Med

5/26/46

CHECK: ☐ WHEEL CHAIR ☐ O. R. ☐ Do Not Write Here TEMP. X-RAY NO. 2706

☐ AMBULATORY ☒ S. RETCHER ☐ PORTABLE

PREVIOUS X-RAYS AT J.C.M.C. ☐ NO ☐ YES-YEAR: ☐ BIRTHDATE 5/11/41 ☐ SEX

TYPE PATIENT: ☐ IN-PAT. ☐ CLINIC ☒ EMERG. ☐ MED. SERVICE ☐ O.P. ☐ OTHER:

EXAMINATION REQUESTED: ☐ ROUTINE ☐ STAT

CLINICAL DIAGNOSIS: Skull fracture, right mandible

PERTINENT HISTORY: Patient seen at J.C.M.C. for facial trauma.

ADDRESS (OUT-PATIENT): 1010 1st St. N.J.

5x7 8x10 9x9 10x12 11x14 14x17 C-NE Dental

4 5

REMARKS: See above

PREPARED BY: REQUESTED BY: L. B. D. MD

DATE: 5/27/73

CODE NO.

REPORT: Patient referred for

11/27/73

149815

Chest:

The heart does not appear enlarged. There is no gross evidence of pneumonic consolidation, atelectasis or pleural effusion. However, the study is unsatisfactory for definite evaluation because on the right costophrenic angle and right lateral chest wall are not completely included in the study.

Skull series, facial bones, nasal bones:

There is no demonstrable fracture or abnormality of the calvarium noted. The sella turcica is not enlarged.

There is a fracture of the vertical ramus of the right mandible near the base of the coronoid process.

Fracture of the right zygomatic arch seen. The maxillary sinuses cannot be well evaluated because of motion during exposure.

No demonstrable fracture of the nasal bones seen.

Dr. Bon Temps/kp

RADIOLOGIST

JERSEY CITY MEDICAL CENTER

CHECK: ☐ WHEEL CHAIR ☐ O. R. ☐ Do Not Write Here
☐ AMBULATORY ☐ STRETCHER ☐ PORTABLE TEMP. X-RAY NO.
 PREVIOUS X-RAYS AT J.C.M.C. BIRTHDATE SEX
☐ NO ☐ YES-YEAR: 6/24/73 M
 TYPE PATIENT: MED.
☒ IN-PAT. ☐ CLINIC ☐ EMERG. ☐ SERVICE ☐ I.O.P. ☐ OTHER:
 EXAMINATION REQUESTED:
☒ ROUTINE ☐ STAT

071
 H-07 CAT
 12/27/73

CLINICAL DIAGNOSIS: X-ray facial bones - HP -
 PERTINENT HISTORY: Waterman - Zygoma arches

ADDRESS (OUT PATIENT)

FILMS USED							CINE	Dev
5x7	8x10	9x9	10x12	11x14	14x17			
	4							

REMARKS:

PREPARED BY: REQUESTED BY: TECH. DATE DONE: 1/4/74
 M.D.

DO NOT WRITE BELOW THIS LINE

REPORT: 1/9/74

CODE NO.

Facial bones:

Postoperative changes seen with metallic wires transfixing fractures of ~~left~~ orbit. Fractured ~~left~~ zygoma is again noted. Fracture segments are in relatively good position. Incidentally noted is almost complete opacity of ~~left~~ antrum.

Dr. Singer/kp

JERSEY CITY MEDICAL CENTER

CHECK: ☒ WHEEL CHAIR ☐ O. R. ☐ Do Not Write Here
☐ AMBULATORY ☐ STRETCHER ☐ PORTABLE TEMP. X-RAY NO.
 PREVIOUS X-RAYS AT J.C.M.C. ☐ NO ☒ YES-YEAR: ☐ BIRTHDATE: 60 yrs SEX: M
 TYPE PATIENT: ☒ IN-PAT. ☐ CLINIC ☐ EMERG. MED. ☐ SERVICE ☐ O.P. ☐ OTHER:
 EXAMINATION REQUESTED: ☐ ROUTINE ☐ STAT

07533-6
 H1613-2
 H-0 CAT
 R. / LOVERME PLA 12/27/73

CLINICAL DIAGNOSIS: Views Zygomatic arch and tomogram of orbits

PERTINENT HISTORY: Trauma

ADDRESS (OUT-PATIENT)

FILMS USED								CINE	Dental
5x7	8x10	9x9	10x12	11x14	14x17				
	3								

PREPARED BY:

REQUESTED BY:

TECH.

DATE DONE

REC'D

DO NOT WRITE BELOW THIS LINE

CC DE NO.

REPORT: 12/28/73

Tomogram of orbits:

There is no evidence of fracture to floor of orbits, on tomograms. Previously described fracture of the right zygomatic bone and arch is once again demonstrated.

Dr. Amir/kp

X-RAY REPORT - DIAGNOSTIC

RADIOLOGIST

ORIGINAL

DEPARTMENT OF RADIOLOGY JERSEY CITY MEDICAL CENTER

CHECK: <input checked="" type="checkbox"/> WHEEL CHAIR <input type="checkbox"/> O. R.		Do Not Write Here TEMP. X-RAY NO.
<input type="checkbox"/> AMBULATORY <input type="checkbox"/> STRETCHER <input type="checkbox"/> PORTABLE		
PREVIOUS X-RAYS AT J.C.M.C.		BIRTHDATE SEX
<input type="checkbox"/> NO <input checked="" type="checkbox"/> YES-YEAR: .		
TYPE PATIENT:		
<input checked="" type="checkbox"/> IN-PAT. <input type="checkbox"/> CLINIC <input type="checkbox"/> EMERG. <input type="checkbox"/> MED. SERVICE <input type="checkbox"/> O.P. <input type="checkbox"/> OTHER:		
EXAMINATION REQUESTED:		
<input type="checkbox"/> ROUTINE <input type="checkbox"/> STAT		

16 m. cl -
1/3/74 149815

X-ray of facial bones (AP, & Waters view)

CLINICAL DIAGNOSIS

PERTINENT HISTORY:

ADDRESS (OUT PATIENT)

FILMS USED							
5x7	8x10	9x9	10x12	11x14	14x17	CINE	Dental
	3						

REMARKS:

PREPARED BY:	REQUESTED BY: <i>Ammon M.D.</i>	TECH. -5 F.	DATE DONE 1-3-74	ROOM 5
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DO NOT WRITE BELOW THIS LINE

REPORT: 1 3 74 CODE NO. 149815

FACIAL BONES:

Once again is noted the fracture to the right zygomatic arch. Also is seen fracture to the lateral wall of the right maxillary antrum. The mandibular fracture has been described previously. The clouding of the maxillary antra as a result of a hematoma in this region.

Dr. *Ammon*



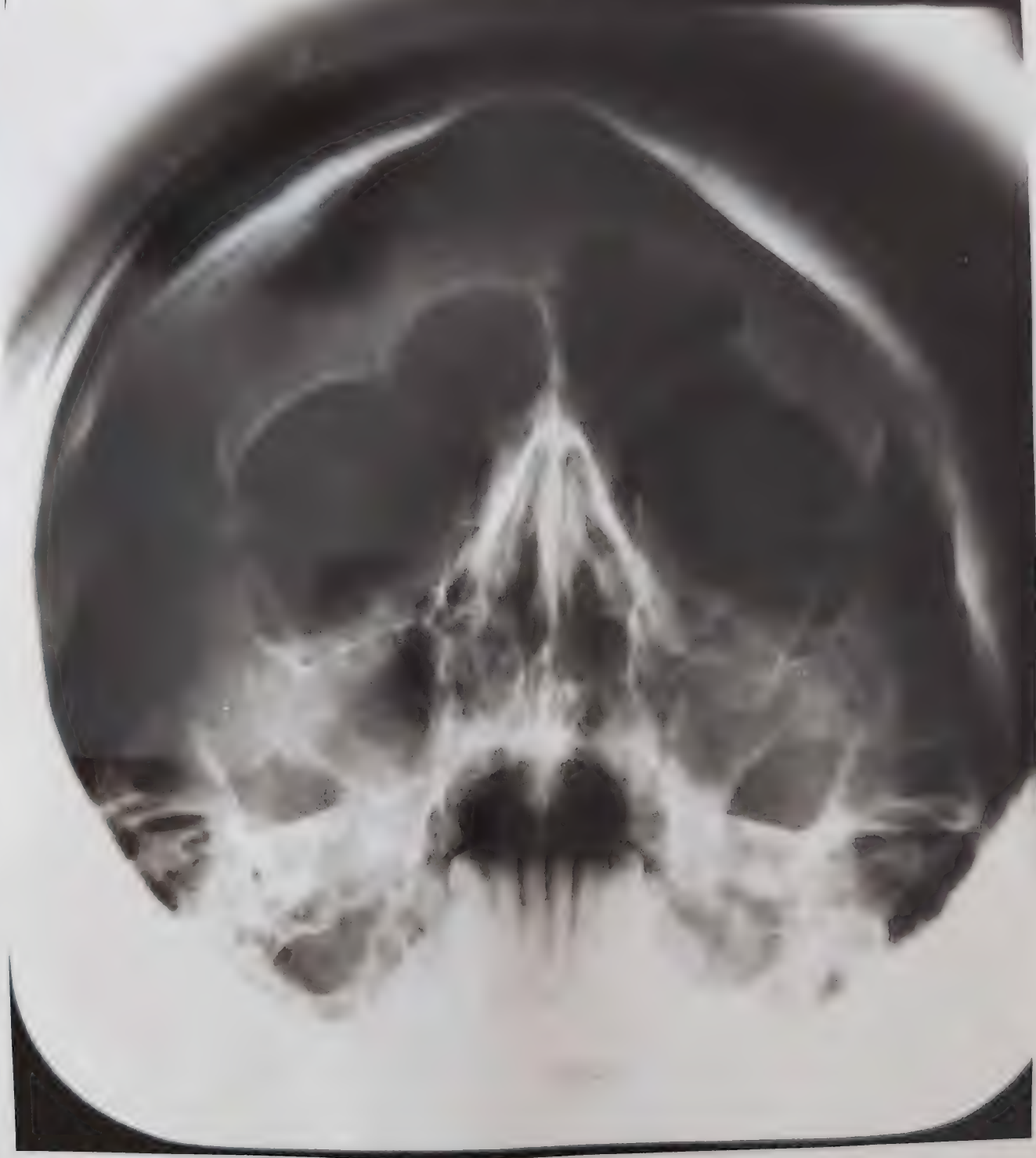
Case No. 2

Fig. 1 : Preoperative front view showing the edema and ecchymosis of the right side of the face .



Case No. 2, fig. 2 : Preoperative lateral view showing the edema and ecchymosis of the right periorbital and mandibular regions of the face and neck; repaired laceration of the right side of the forehead.

3 JAN 74 LER
MEDICAL CENT
JERSEY CITY
JF 149815



Case No. 2 ; fig. 3 : Water's view of the facial bones showing the Trimalar fracture of the right zygoma, and clouding of both maxillary sinuses .



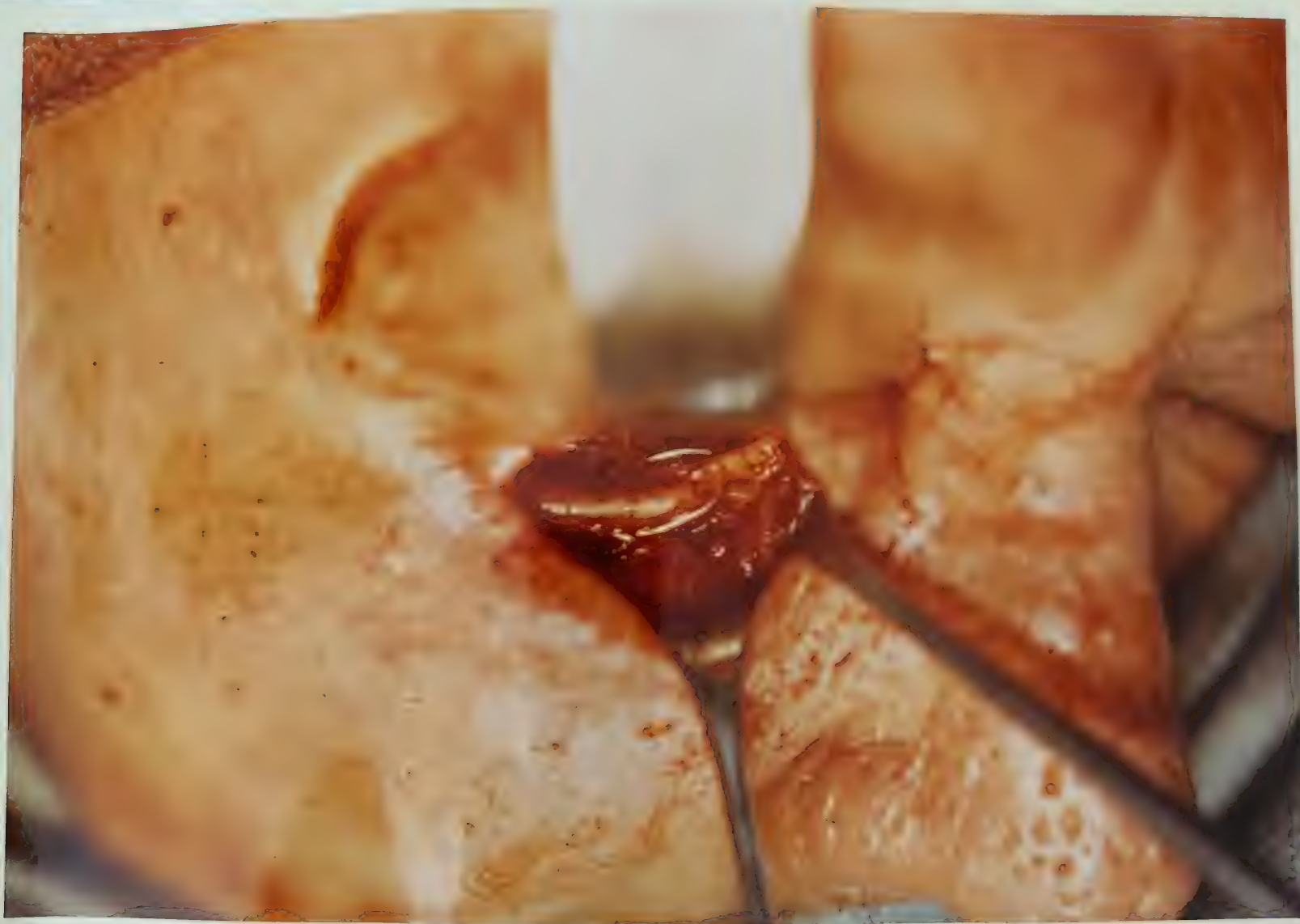
Case No. 2 ; fig. 4 : Submental-vertical projection of the zygomatic arches demonstrating the minimally displaced fracture of the right zygomatic arch .



Case No. 2 ; fig. 5 : Tomogram of the orbits showing the fracture of the right zygomatic bone and clouding of the maxillary sinuses. No evidence of fracture of the orbital floor.



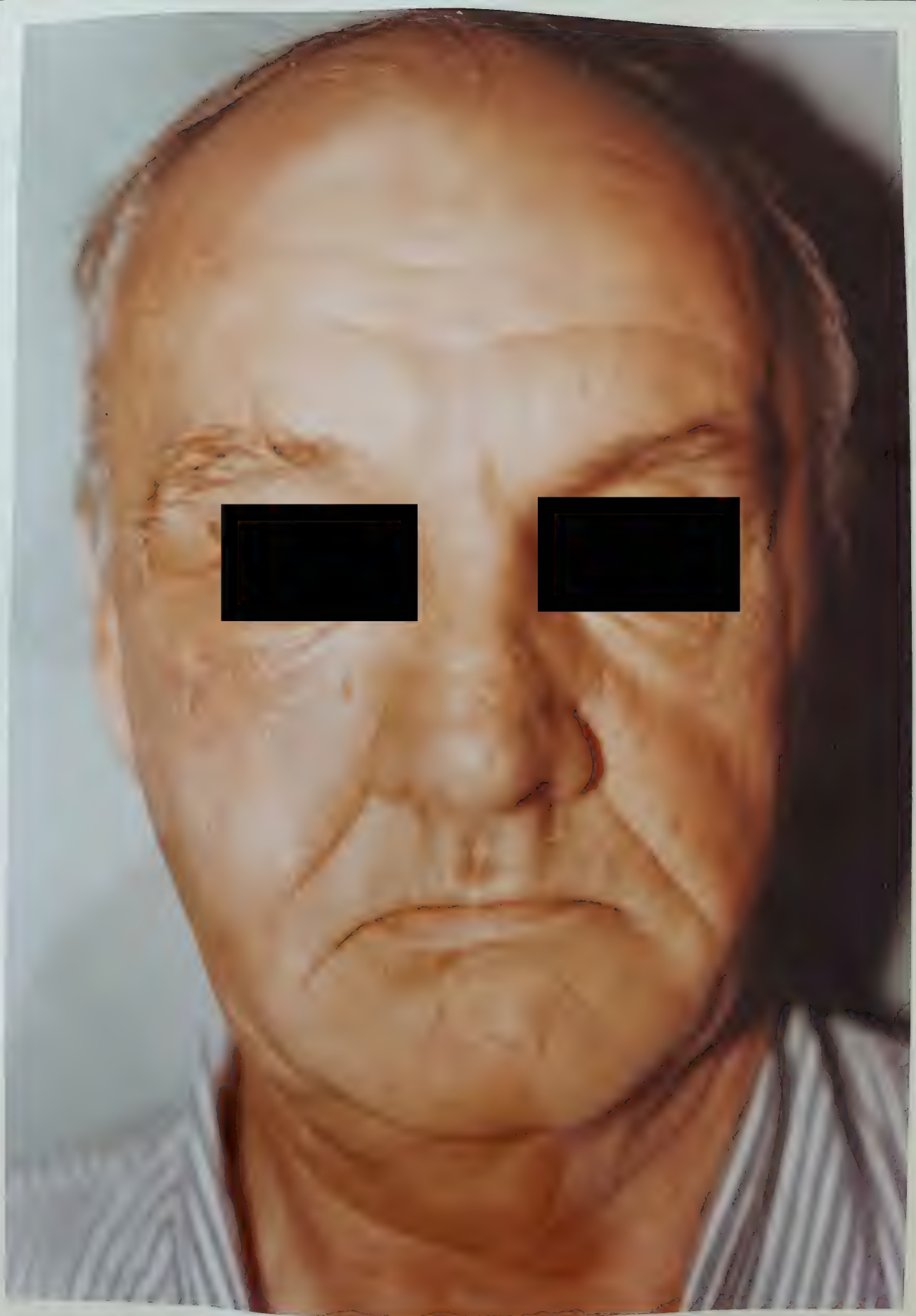
Case No. 2 ; fig. 6 : Operative view showing the incisional lines over the infraorbital and lateral eyebrow regions for the open-reduction of the fractured right zygoma. An Epidermal inclusion cyst of the lower eyelid was also excised .



Case No. 2 ; fig. 7 : Interosseous wiring of the infraorbital zygomatico-maxillary fracture site of the right zygoma following re-alignment of the displaced fracture. Similar wiring was performed for the fracture line of the zygomatico-frontal region.



Case No. 2 ; fig. 8 : Postoperative Water's view showing the interosseous wire fixation of the right Trimalar fracture at both the zygomatico-maxillary and zygomatico-frontal regions.



Case No. 2 ; fig. 9 : Front view of the patient in the early post-operative period.



Case No. 2 ; fig. 10 : Lateral view in the early postoperative period.

3. Category Three : Traumatic defects requiring reconstructive surgery.

Case No. 3 :

Hypertrophic post traumatic scar deformity of face.

Case Summary

Candidate's name : Sami M. Mamoun, M.D.

Category Three : Traumatic defects requiring Reconstructive Surgery.

Case No. 3 :

Hypertrophic post traumatic scar deformity of face.

This 21 year old black female was admitted with a large hypertrophic scar deformity of the left side of her face. About one year prior to admission, she sustained a razor blade vertical laceration of the left side of her face, and this was repaired by direct suture approximation in the emergency room at that time. Pertinent details concerning the post operative course were not available to us. However, the patient did not recall having had any post operative wound infection. Moreover, she had no previous history of hypertrophic or keloid scar formation. Over a period of about eight months the scar over the left side of her face gradually hypertrophied, became itchy and acquired a firm to hard consistency. During the past few months prior to surgery, the scar appeared to have settled down. The irritation subsided, and there was no further change in its size or consistency (figures 1 & 2).

The patient denied having had any previous x-ray irradiation or steroid injections of that scar. However, her main complaint was that she always felt unusually embarrassed about the presence of that hypertrophic scar deformity on the left side of her face, to the extent that she always had to keep that portion of her face covered with a scarf or bandage, especially during her work hours or among her friends. On admission, the scar measured approximately 10 cm in length, 1 cm in width, and approximately 1 cm in elevation. There was no clinical evidence of injury to any of the facial nerve branches.

The plan for this patient was to excise that scar, in toto, infiltrate the local tissues with steroid solution, and to administer post operative radiation therapy.

Under local anaesthesia, using 1 per cent xylocaine with adrenaline infiltration and general sedation, the hypertrophic scar was completely excised down to the subcutaneous tissue (figure 3). The margins were undermined for a width of approximately 1 cm. Complete hemostasis was achieved, using the disposable hand cautery. Throughout the procedure, we maintained the number of sutures and foreign buried suture material to the minimum. Following the advancement of the flaps, using few buried chromic sutures, the skin edges were approximated with continuous pullout suture of No. 5-0 nylon. Steri-Strips were next applied for further exact approximation and support of the skin edges. During the procedure the tissues were infiltrated with 1 c.c. of 40 mg of Kenalog. Within a few hours post op, the patient was given 500 rad units of x-ray therapy, which was repeated one week post op. The post operative course was smooth (figures 5 & 6), and there was no recurrence of scar hypertrophy when the patient was seen ~~One~~ one month post operatively.

Sami M. Mamoun M.D.

OPERATIVE RECORD

660-2

1

16 Med.

081170

LOCATION (OR ADDRESS)

UNIT NUMBER

Preoperative Diagnosis Complete

Post-Traumatic Keloid Scar of Lt. Side
of Face.

CONDITION OF PATIENT

Temperature	Respiration	Pulse	Blood Pressure	General Condition

Anesthetic Local Xylocaine 1% with Epinephrine
Condition during Anesthesia (Pulse, Respiration, Stimulants, etc.)Operation Excision of Keloid Scar of Lt. Side
of Face.
Advancement of Flaps & Plastic Repair.
- Began Closed

Date 12/20/73

Doctor Lo Verme

Postoperative Diagnosis

Same

Surgeon Dr. Mamoun

Anesthetist " "

Assistants Dr. Lo Verme

Dr. Gianetti

Instrument Nurse

Sponge Nurse

Findings: ~~Excision of Keloid Scar of Lt. Side of Face. Advancement of Flaps & Plastic Repair.~~
Operation (Cont'd.): Local Injection of Steroid (Kenalog).

~~What was found~~ PATHOLOGICAL FINDINGS: About one year ago this 21 y o N/F was hit by a razor blade over the left side of her face, thus sustaining a laceration in that area of her face. She was brought to the Emergency Room of this hospital where the facial laceration was sutured. However, she healed by developing a keloid scar, which gradually enlarged in size and became irritable and itchy. Gradually the latter reaction settled down and the keloid became less itchy and stopped growing in size. However, the patient became self-conscious of this keloid scar over the left side of her face and was embarrassed to show that side of her face at work and she used to hide the left side of her face most of the time. She had no previous steroid injections and no history of previous X-Ray treatment for the keloid, for unknown reason. Today, the plan for this patient was to excise the keloid scar of the left side of the face and to repair the area, applying minimal sutures and infiltrate the region with Kenalog steroid. 1 cc. of 40 mg. of Kenalog were used in the latter process. The scar of keloid measured approximately 10 cm. in length and 1 cm. in width and approximately 1 cm. in elevation and felt firm in consistency. It was located on the left side of her face, approximately 1" anterior to the preauricular crease and it extended from the temporal region of the scalp and inferiorly almost to the level of the angle of the mandible.

OPERATIVE TECHNIQUE: Using 1% Xylocaine with 1:100,000 Adrenalin local infiltration of the keloid scar and following preparation of the face with Betadine and proper draping, the keloid itself was outlined with Methylene Blue along its margins. The keloid was excised leaving a very thin layer of scar at the base and barely showing the subcutaneous fatty layer. The branches of the facial nerve were spared any

Immediate Postoperative Condition (Hemorrhage, Shock, etc.)

(over)

Dictated by: Dr. Mamoun

Signature of Operator Sami Mamoun M.D.

Transcriber: Mary Geremia

Date Dictated: 12/20/73

Date Typed: 1/15/74

(CONTINUE ON REVERSE SIDE)

possible injury and there were a few bleeders which were controlled with the except hand cautery. Slight undermining of the skin edges using a scalpel was performed, extending the dissection of the skin edges for approximately $\frac{1}{2}$ cm. in width on either side. The deep dermal layers on either side were approximated with three or four sutures of #4-0 chromic catgut and the skin edges were approximated with continuous subcuticular pull-out suture of #5-0 nylon. Subsequently, five or six interrupted sutures of #6-0 nylon were loosely applied in a few areas on the skin side. Steri-strips were next applied to approximate further and to support the skin edges. Patient tolerated the procedure satisfactorily and no pressure dressing was applied. She was sent to her room in general good health.

Samu Mamoun
Dr. Mamoun

CATALOG
NO 6022

MEDICAL CENTER - JERSEY CITY, N.J.

PATHOLOGY REPORT

LAST NAME

FIRST NAME

Dr. LoVerme

16 Med.

076753-3, 031170

LOCATION

UNIT NUMBER

Specimen No. S73-2804 Date 12/20/73

Operation Excision of scar on face

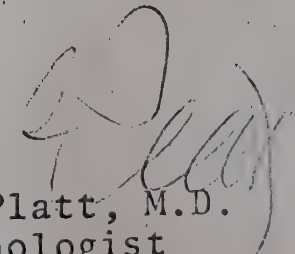
GROSS DESCRIPTION: Specimen designated as scar of face is received with formalin and consists of a strip of ellipised shaped, brown, firm scar tissue, measuring 8 x 1 x 0.8 cm.

2 Rep. sections taken.

N. David, M.D.

MICROSCOPIC DESCRIPTION: Sections reveal hyperkeratotic skin with focal fibrosis of the dermis.

DIAGNOSIS: SCAR OF SKIN, FACE.
01-4806


R. Platt, M.D.
Pathologist

12/21/73
RP/dr



Case NO. 3 ; fig. 1 : The post-traumatic hypertrophic scar deformity of
the left side of the face .
Pre op.



Case No. 3 ; fig. 2 : Close-up view of the post-traumatic hypertrophic scar deformity of the left side of the face.



Case No. 3 ; fig. 3 : Operative view of the limits of the excisional outline of the hypertrophic scar deformity of the left side of the face .



Case No. 3 ; fig. 4 : Following approximation of the dermal layers with a few fine chromic sutures, and application of a few fine nylon sutures to the skin edges , steri-strips (re-inforced with Tincture of benzoin) were used as the main approximator of the skin edges.



Case No. 3 ; fig. 5 : **One** month postoperative view showing satisfactory healing of the facial scar .



Case No. 3 ; fig. 6 : Close-up view of the left side of the face, **One** month postoperatively .

4. Category Four : Aesthetic operations .

Case No. 4 :

Bilateral mammary hypoplasia .

Case Summary

Candidate's name: Sami M. Mamoun, M.D.

Category Four: Aesthetic Operations.

Case No. 4: ...
Bilateral Mammary Hypoplasia.

This 36 year old white female nurse was admitted to our service with bilateral mammary hypoplasia (Fig. 1, 2 & 3). She had previously requested bilateral augmentation mammoplasty, and plans were made to use Silastic implants for the latter procedure. The patient was divorced, had one daughter, and although she did not discuss with us her future personal plans, it appeared that she had a desire to remarry. Among the reasons for requesting our assistance was the fact that she had a moderately flat-chested appearance, which was causing her a certain degree of embarrassment in her social life. Her facial expressions and personality were otherwise pleasant. A certain degree of breast atrophy had occurred during the past few years, resulting in her present appearance.

Examination of the breast revealed a moderate degree of mammary hypoplasia, but no ptosis or chest wall deformities, and no breast nodules.

Following detailed discussions with the patient, we decided to use the small 145 cc round Silastic gel implants, which have the silicone backing. The patient had a thin, short build, and she did not desire a larger size implant. Moreover, it was planned to perform the procedure under general anaesthesia and proper sedation.

Preoperatively, with the patient in the sitting up position, the mid-clavicular and submammary fold lines were marked on her chest. A slightly curved 2.5 in line was drawn on each breast, approximately 1 cm above the submammary fold line, with its center slightly lateral to the mid-clavicular line, so that the final scar will be hidden within the lower con fines of a bra. (Fig. 4). In addition, we planned to implant the silastic breast prosthesis in the suprapectoral level.

The procedure was first started by marking the extent of dissection of the submammary pocket, using the mammary plastic marker cup. The latter extended approximately to the second rib superiorly, the anterior axillary line laterally, and close to the sternal border medially. The mammary tissue was dissected off the aponeurosis of the external oblique and the pectoralis major muscle and fascia, using both sharp and blunt dissection. Finally, the implants were inserted, incisions sutured, and supportive dressings applied.

On the second post operative day, the dressings were removed, and a proper size bra applied. The patient was cautioned against any physical strain on her shoulders and arms for a total period of six weeks post operatively.

Her post operative course was smooth and uncomplicated (Fig. 5, 6 & 7). She was pleased and satisfied with the operative results, and she went back to work about ten days post operatively.

Sami M. Mamoun M.D.

OPERATIVE RECORD

11 Med.

085047

660-2

LOCATION (OR ADDRESS)

UNIT NUMBER

Preoperative Diagnosis Complete

Bilateral Mammary Hypoplasia.
Nevus of the Left Nasolabial Fold.

Date 12/20/73

Doctor Lo Verme

Postoperative Diagnosis

Same

CONDITION OF PATIENT

Temperature	Respiration	Pulse	Blood Pressure	General Condition

Anesthetic General

Condition during Anesthesia (Pulse, Respiration, Stimulants, etc.)

Operation Bilateral Augmentation Mammoplasty.
Insertion of Silastic Implant,
Bilateral.

Excision of Nevus of Lt. Nasolabial
Fold.

Began 12:00 Noon Closed 2:15 P.M.

Surgeon Dr. Mamoun

Anesthetist Drs. Vea & Sullivan

Assistants Dr. Lo Verme

Dr. Gianetti

Dr. Egtegar

Instrument Nurse V. De Vries, R.N.

Sponge Nurse D. Battaglia, R.N.

Findings (Gross): Describe all Pathological Findings and All Organs Explored, Normal and Abnormal

This 36 y o W/F nurse was complaining of bilateral hypoplasia of the breasts. She desired to have an augmentation mammoplasty performed on her. Moreover, the patient had a small nevus along the left nasolabial fold, which was excised today under general anesthesia. The augmentation mammoplasty was performed and a round Silastic implant of the 145 cc. size was inserted, one on either side. The round Silastic implant has Silicone backing. The patient had a thin body structure and it was elected to use What was done the round small Silastic implants. The patient had no desire to have a larger implant.

Preoperatively with the patient in the standing position, the mid-clavicular ^{line} extending to the nipple was drawn with Gentian Violet, intersecting the inframammary crease line which was also outlined with Gentian Violet.

Under general anesthesia and following preparation of the chest with Betadine and proper draping, a mammary prosthesis marker was used in order to outline the extent of dissection of the submammary pocket. The operative incision was marked, having a length of approximately 2", and it was located about $\frac{1}{2}$ to 1 cm. superior to the inframammary crease line. The latter incisional line was drawn in order to fit within a Bikini, and to be hidden by the latter. ~~incision, this line was located by the mid-clavicular line~~

The incision was made through the skin and subcutaneous tissue and an apron of subcutaneous fat was maintained on the superior portion of the incision. The incision was extended through the subcutaneous tissue, superficial fascia down to the pectoralis muscle fascia. Subsequently, the dissection of the submammary pocket was performed using sharp and blunt dissection, elevating the mammary tissue off the pectoralis muscle fascia. The pocket was dissected according to the outline drawn on the skin fitting the desired size of the prosthesis, and following the mammary prosthesis

Immediate Postoperative Condition (Hemorrhage, Shock, etc.)

(over)

Dictated by: Dr. Mamoun

Signature of Operator Sami Mamoun M.D.

Transcriber: Mary Geremia

Date Dictated: 12/20/73

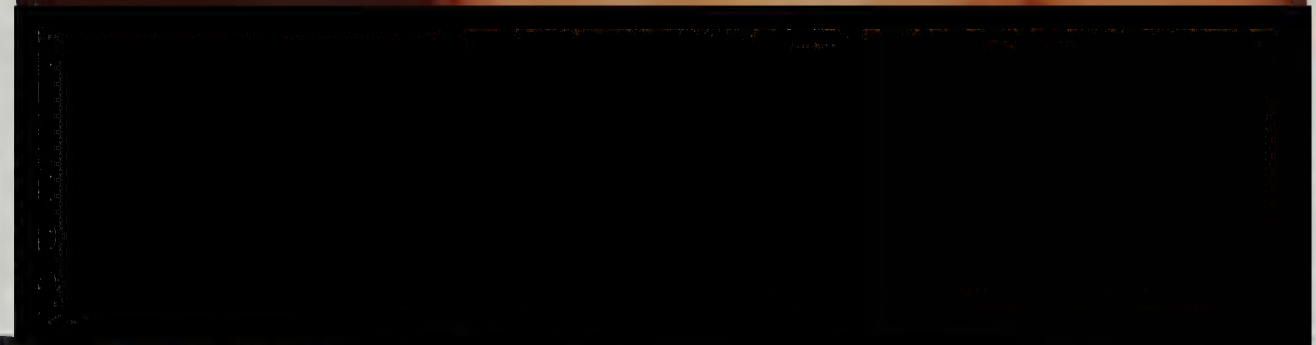
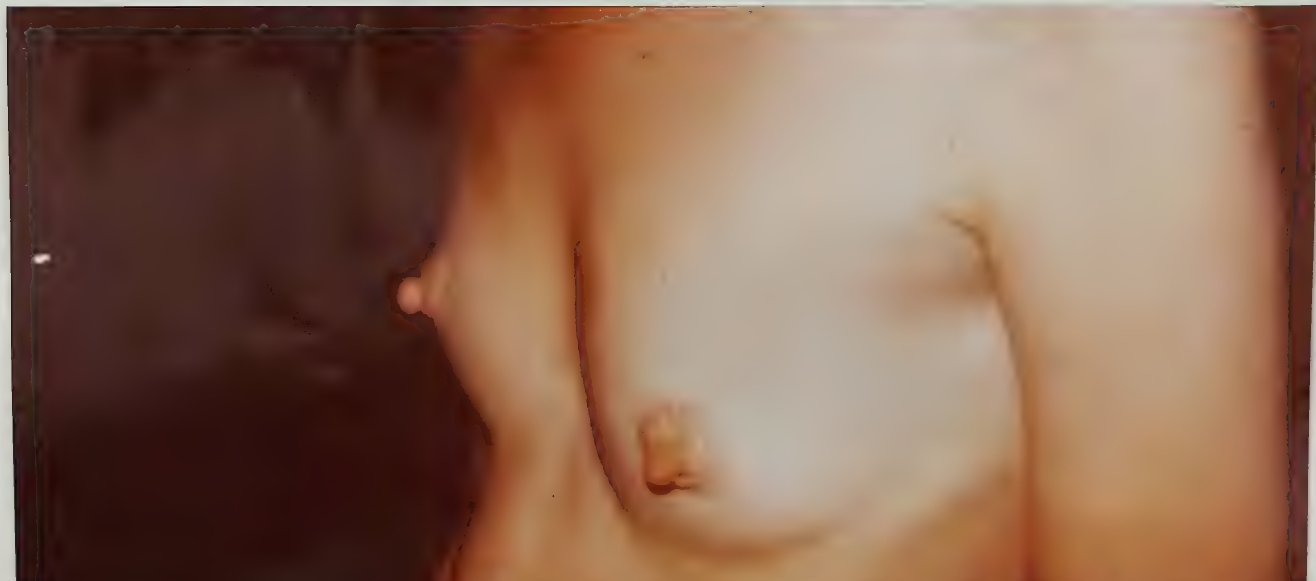
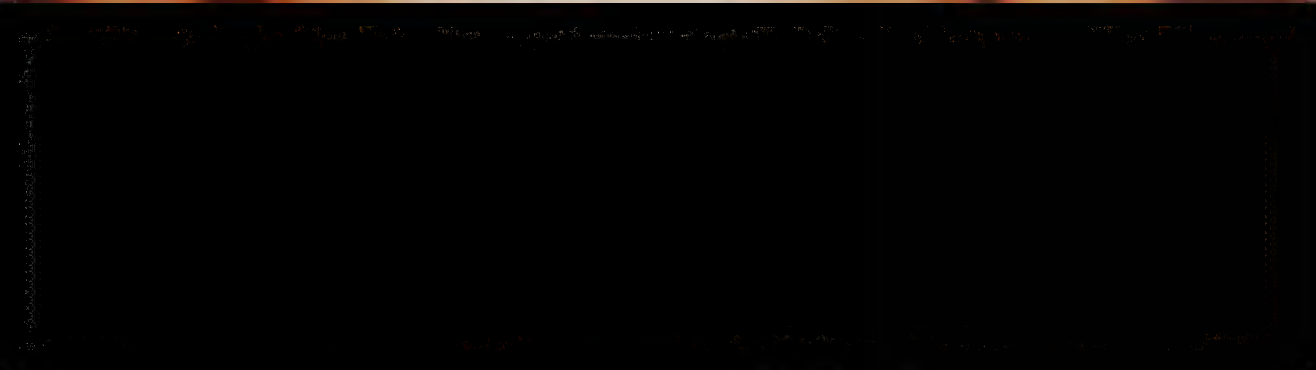
Date Typed: 1/21/74

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earlier outline. Continuation of the pocket dissection was extended inferiorly along the inferior margin of the incision for a distance of approximately 1 cm. All bleeders were electrocoagulated and following complete hemostasis the pocket was irrigated with a solution of Saline, containing 1 gm. of Tetracycline. The implants were inserted and these were of the 145 cc. Silastic Meyer-Schultz implants. Subsequently the incisional lines were closed using 4-0 chromic catgut for the deep dermal layer and using 5-0 and 6-0 nylon for the skin edges. Dressing was applied in addition to elastoplast.

Subsequently, the face was prepped with dilute Betadine soap and properly draped and the small nevus along the left nasolabial fold, which measured approximately 3 mm. in diameter, was outlined with Methylene Blue along the nasolabial fold region and excised. The skin edges were approximated with a few sutures of 6-0 nylon. A small dressing was applied. Patient tolerated the procedure satisfactorily and was sent to the Recovery Room in general good health.

Sami Mamoun M.D.
Dr. Mamoun



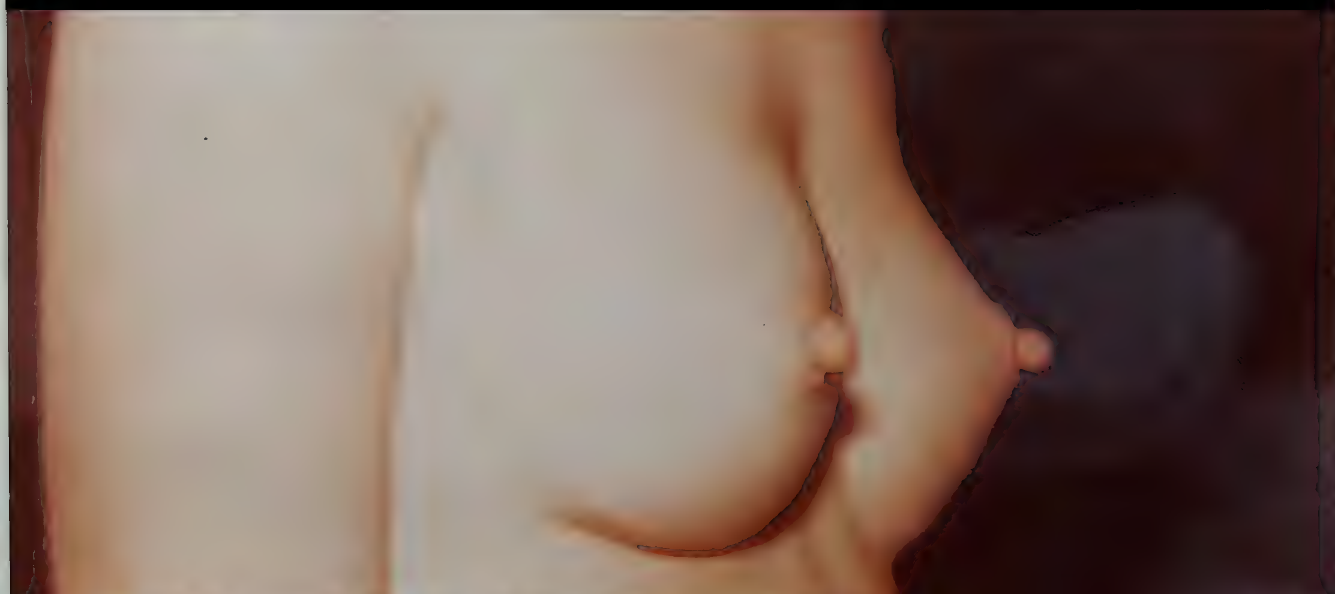
Case No. 4 ; figs.1 & 2 : Preoperative front and right oblique view showing the patient with bilateral mammary hypoplasia .



Case No. 4 ; fig. 3 : Preoperative left oblique view of the patient.



Case No. 4 ; fig. 4 : Postoperative view of the patient in the recumbent position two months following augmentation mammoplasty (using the round Silastic implants), showing the outline of the inframammary incisions .



Case No. 4 ; figs. 5 & 6 : Front and left oblique views two months post augmentation mammoplasty .



Case No. 4 ; fig. 7 : Right oblique view two months post augmentation
mammoplasty .

5. Category Five : Malignancies or conditions prone to malignancy.

Case No. 5 :

Squamous cell carcinoma of the dorsal first web region
of the right hand .

Case Summary

Candidate's Name: Sami M. Mamoun, M.D.

Category Five: Malignancies or Conditions Prone to Malignancy

Case No. 5:

Squamous Cell Carcinoma of the Dorsal First Web Region of the Right Hand

This patient was a blind 83 year old white female, who was brought to our clinic by her son for the treatment of a tumor involving the dorsal first web region of her right hand (Fig. 1 & 2). The patient herself had a poor recollection of the facts related to that tumor. However, her son mentioned that she had had it for a period of about two years, and never consulted a physician for it. He described that tumor as a slowly growing lesion that started on the dorsal surface of the first web region of the right hand, and gradually grew in size. On admission, the tumor measured approximately 2.5 in. in diameter, involving the entire dorsal region of the first web space of the right hand and the dorso-medial region of the thumb MP joint. It was a painful, tender, ulcerating, fungating tumor, with purulent discharge, and a surrounding zone of inflammatory reaction. Moreover, there was moderate limitation of movements of the thumb at the MP joint region. A biopsy of the tumor revealed a well differentiated Squamous cell carcinoma.

The plan for this patient was to attempt at performing a total local excision of that tumor, and to try to avoid a more radical procedure. This was discussed with the patient's family, and agreed upon. On consultation with the anaesthesiologist, and due to the patient's poor cardiopulmonary reserve, it was decided to perform the procedure under regional block at the wrist in addition to general sedation. A tourniquet could not be used for various reasons.

A total local excision of the tumor was performed, including a 1.5 cm circumferential margin of grossly normal looking skin. Portions of the first dorsal interosseous and adductor muscles had to be resected en bloc with the tumor, since they were suspected of being grossly involved. Moreover, a superficial portion of the MP joint capsule of the thumb (dorso-medial region) had to be shaved off, without disturbing the synovial membrane itself. The digital neurovascular bundles, and the extensor tendons of the thumb and fingers were found intact and were also spared. The defect (Fig. 3) was covered with porcine skin (Fig. 4), awaiting final results of the pathological examination. The latter later revealed tumor involvement in the deepest central margin of the specimen. One week post operatively, further excision of a superficial zone of tissues from the central region of the defect was performed, and the defect was covered with a split thickness skin autograft, taken from the right thigh (Fig. 5). A 2x1 cm area in the central region of the graft failed to take, and had to be grafted again two weeks later. Subsequently, the skin grafts healed well.

In spite of some difficulties concerning the patient's motivation and response to our physiotherapy post operatively, we believe that we have helped her attain a satisfactory result. Figures 6, 7, & 8 of the involved hand were taken six months post operatively, to show the patients gripping ability. There was no evidence of tumor recurrence.

Sami M. Mamoun, M.D.

660-2

7 Med.

003867

LOCATION (OR ADDRESS)

UNIT NUMBER

Preoperative Diagnosis Complete

Squamous Cell Ca. of Rt. Hand

Date 7/19/73

Doctor Lo Verme

Postoperative Diagnosis

CONDITION OF PATIENT

Temperature	Respiration	Pulse	Blood Pressure	General Condition

Same

Anesthetic Xylocaine 1% + O₂, Valium I.V.

Condition during Anesthesia (Pulse, Respiration, Stimulants, etc.)

Surgeon Dr. Mamoun

Anesthetist Dr. Dolorico - Stand-by

Assistants Dr. Lo Verme

Dr. L. Reddy

Excision Squamous Cell Ca. Rt. Hand
Operation & Application of Xeroderm Graft, Rt. Hand.

Instrument Nurse Harrigan/De Vries

Sponge Nurse De Ciancia/Boyle

Began 11:30

Closed 1:10 P.M.

Findings (Gross): Describe all Pathological Findings and All Organs Explored, Normal and Abnormal

What was done

Under I.V. analgesia and using median nerve block and regional wristlet blocks, the tumor over the radial dorsal region of the right hand was outlined with Methylene blue, keeping a margin of approximately 1.5 cm. of normal looking skin around the periphery of the tumor. The skin incision was made following the outline drawn around the tumor and the tumor was dissected off and excised. A portion of the first dorsal interosseous muscle had to be resected and a portion of the adductor muscle also had to be resected together with the tumor, since the latter was found to be attached to the superficial surface of these muscles. The dorso ^{medial region of the} capsule of the metacarpal ^{phalangeal} joint of the thumb had to be shaved off together with the tumor and we attempted not to go through the joint synovial membrane. The dorsal fascia of the hand in that region was excised, in addition to the dorsal veins and carpal radial artery branch. The latter artery was found to be markedly sclerosed and it was clamped and ligated with #4-0 chromic catgut and excised together with the tumor. The digital vessels and nerves to the thumb were spared and not excised. Moreover, the extensor tendons of the fingers and thumb were also spared and the tumor was not found to be attached to these tendons. Following complete hemostasis, the area was covered with pigskin and a dressing of Xeroform and 4 x 4 gauze and hand dressing was applied. It was elected not to apply an autogenous skin graft at this time because we decided to delay the latter procedure until we obtain the results of the pathology in order to determine the depths of involvement of the tumor in our specimen and whether any tumor was left in the bed, deep in Immediate Postoperative Condition (Hemorrhage, Shock, etc.) the dorsal region of the hand. (over)

Dictated by: Dr. Mamoun

Signature of Operator Sami Mamoun M.D.

Transcriber: Mary Geremia

(CONTINUE ON REVERSE SIDE)

Moreover, we could not use a tourniquet for this procedure due to technical difficulties, and because of the minute oozing of blood it was decided to apply pigskin for temporary coverage and to apply a skin graft within a period of one week. The patient is known to be blind and we elected to attempt not to perform any radical amputation on her hand, if possible.
of the involved portion of

Sami Mamoun M.D.
Dr. Mamoun

Preoperative Diagnosis Complete ()

Squamous Cell Carcinoma of
the Dorsal Region of the
Right Hand

CONDITION OF PATIENT

Temperature	Respiration	Pulse	Blood Pressure	General Condition

Anesthetic Local

Condition during Anesthesia (Pulse, Respiration, Stimulants, etc.)

Operation See Below

Began 8:45 a.m. Closed 9:45 a.m.

Date 7/26/73

Doctor LoVerme

Postoperative F

Surgeon Dr. Mamoun

Anesthetist Dr. Mamoun

Assistants Dr. Lo Verme/Dr. L. Reddy
Dr. Mastromonaco

Instrument Nurse Norton

Sponge Nurse DeVues

Operation:

Split Thickness Skin Graft (Right Side, Anteriorly to the Re-
cipient Bed over the Dorsal Region of The Right Hand.

Findings:

This 33 y o W/F had squamous cell carcinoma over the dorsal re-
gion of the right hand involving the first web space and the
dorsal region of the thumb and MP joint region of the index and
middle fingers, over an area of approximately 3 x 2.5". The
tumor was fungating, ulcerating and it was excised one week ago
and the bed was covered with pigskin xerograft in preparation
for skin grafting today. The specimen confirmed the diagnosis
of squamous cell carcinoma, but microscopic examination reveal-
ed that the tumor extended across the deep region of the speci-
men indicating the probable persistence or presence of some tu-
mor tissue left behind in the bed region. Today, some more
tissues were excised from the center of the defect over the right
hand using 1% Xylocaine regional anesthesia, namely, infiltration
of the median and radial nerve regions in the right wrist. It
was decided not to perform any radical surgery, such as amputa-
tion, since the general condition of the patient would not tole-
rate it and the family objected against performing such a proce-
dure. The patient is blind.

(SEE REVERSE SIDE FOR OPERATIVE PROCEDURE)

Immediate Postoperative Condition (Hemorrhage, Shock, etc.)

Dictated by: Dr. Mamoun

Signature of Operator Sami Mamoun M.D.

Transcriber: Karen Miller

(CONTINUE ON REVERSE SIDE)

Procedure:

A split thickness skin graft was taken by the Brown dermatome from the anterior right thigh region and the donor site was dressed with meshed gauze. The graft was applied over the recipient bed of the tumor of the dorsal region of the right hand and the graft was transfixed in place with steri-strips. Xeroform dressing and hand dressing were applied. The patient tolerated the procedure well and a volar splint of plaster-of-paris was applied with the wrist in slight extension and the hand in functional position. The patient tolerated the procedure well and was sent to the Recovery Room in general good health.

Sami Mamoun M.D.
Dr. Mamoun

PATHOLOGY REPORT

OPD - Dr. Joson

LOCATION

UNIT NUMBER

Specimen No. S73-1463

Date 6/27/73

Operation from rt. hand

Pre Op Dx: ulcerative lesion of rt. hand

GROSS DESCRIPTION: Specimen consists of one fragment of grayish white soft tissue that measures 0.8 x 0.3cm.

Entire specimen submitted

G. Marofri, M.D.

MICROSCOPIC DESCRIPTION: Sections through skin show a well-differentiated squamous cell carcinoma. Strands of squamous epithelium are seen infiltrating the dermis. Chronic inflammation is present.

PATHOLOGICAL DIAGNOSIS:

SKIN OF RIGHT HAND SHOWING SQUAMOUS
CELL CARCINOMA.

0100 - M-8073

C. L. Strand

C.L. Strand, M.D.

7/2/73

Date

7/26/73

Specimen No.

S73-1685

A) Dorsum of rt. hand over 1st interosseous muscle
Operation B) Dorsum of rt. hand from peripheral area of lesion

Pre Op Dx: Post excision CA Right hand

GROSS DESCRIPTION: A) Specimen consists of five minute fragments of grayish pink tissue ranging in size from 0.2cm up to 0.4cm

Entire spec. sub.

B) Specimen consists of four fragments of irregular grayish minute tissue ranging in size from 0.2 up to 1cm by 0.3cm

Entire spec. sub.

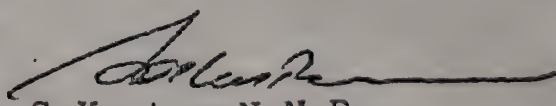
N. David, M.D.

MICROSCOPIC DESCRIPTION: A) Examination reveals fragments of fibrino purulent material and non specific granulation tissue. No residual carcinoma is identified here.

B) Examination reveals fibrous tissue infiltrated with leukocytes. There is no evidence of residual carcinoma.

PATHOLOGICAL DIAGNOSIS:

SKIN, GRANULATION TISSUE SHOWING NO EVIDENCE OF RESIDUAL CARCINOMA, HAND, BIOPSY.

A

S. KustermN, M.D.

7/30/73



Case No. 5 ; fig. 1 & 2: Preoperative views of the squamous cell carcinomatous tumor involving the dorsal first web region of the right hand.



Case No. 5; fig. 3: Operative view of the defect following total excision of the squamous cell carcinoma of the dorsal first web region of the right hand.



Case No. 5; fig. 4: Porcine skin applied over the defect as a temporary biologic dressing.



Case No. 5; fig. 5: One week post tumor excision, the defect was covered with split thickness autograft, transfixed in position with Steri Strips.



Case No. 5; fig. 6: Six months post operative view of the dorsum of the right hand, with fingers in extension.



Case No. 5; fig. 7: Six months post operative view of the right hand, with the fingers in flexion. Note residual adduction contracture of the thumb. No tumor recurrence.



Case No. 5; fig. 8: Six months post operative view of the volar surface of the right hand.

6. Category Six : Plastic surgery of the hand .

Case No. 6 :

Traumatic severence of the extensor tendons of the right index and middle fingers at the level of the metacarpophalangeal joints .

Case Summary

Candidate's Name: Sami M. Mamoun, M.D.

Category Six: Plastic Surgery of the Hand

Case No. 6: Traumatic Severance of the Extensor Tendons of the Right Index and Middle Fingers at the Level of the Metacarpophalangeal Joints.

This 65 year old black male (retired machine operator) was admitted to our service through the emergency room with multiple stab wound lacerations of both hands and face. The laceration of the right hand extended transversely across the dorsal surface of the MP joints of both the index and middle fingers, and measured approximately 5.5 cm in length. The MP joint of the index finger was exposed dorsally due to severance of the extensor hood mechanism and the joint capsule in that region, with resultant flexion deformity of the proximal phalanx. Moreover, there was partial severance of the extensor hood of the middle finger just distal to the MP joint (Fig. 1). In addition, the patient had skin lacerations of the dorsal regions of the ring finger and of the left wrist, with no tendon involvement. He also had two small lacerations of the left side of his face.

The plan for this patient was to perform primary repair of the severed extensor tendons, as well as repairing all other hand and facial lacerations. Within a couple of hours, the patient was taken to the operating room, and, under general anaesthesia, a tourniquet was applied and right hand lacerations explored. Thorough irrigation of the wounds with saline was performed. Subsequently, the severed joint capsule was repaired using interrupted horizontal mattress sutures of 4.0 Mersiline. Similarly, the extensor hood was repaired using 4.0 Mersiline interrupted horizontal mattress sutures (Fig. 2). A running suture of 5.0 Nylon was then applied for further approximation of the edges of the extensor hood (Fig. 3), followed by skin closures (Fig. 4). Throughout the repair procedure, and during the application of the dressing, an assistant was maintaining the MP joint in extension. Subsequently, a dressing was applied using a volar plaster splint (Fig. 5).

The post operative plan for this patient was to keep the index and middle finger MP joints splinted in extension for 4-5 weeks, followed by removal of the splint and beginning of active motion and warm soaks. Passive in addition to active exercises were to start in a graded manner around the fifth to sixth week after repair.

Figures 6 and 7 show the patient's hand three weeks post operatively.

Sami M. Mamoun, M.D.

COLLEGE OF MEDICINE AND DENTISTRY OF NEW JERSEY

MARTLAND HOSPITAL
NEW JERSEY MEDICAL SCHOOL
65 Bergen St. Newark, N. J. 07107

NAME: U-03443-1

DIVISION: Plastic Surgery WARD: 9N

DATE: January 9, 1974 OPERATION BEGAN: 2:10 p.m.

OPERATION ENDED: 4:15 p.m.

PREOPERATIVE DX: Multiple stab wound lacerations of left side of face and dorsum of both hands. Severed extensor tendon hood of right index and of right middle finger. Severed MP joint capsule of right index finger (dorsal)

POST-OPERATIVE DX: Same.

OPERATION PERFORMED: Exploration of stab wound lacerations of dorsum of right hand. Suture repair of severed joint capsule and extensor tendon hoods of right index and middle finger, at the level of the metacarpal phalangeal joint. Repair of laceration of right ring finger (dorsal proximal interphalangeal region) and of multiple lacerations of left side of face.

SURGEON: Dr. Mamoun

SURGICAL NURSE: Mrs. Richards

1st. ASSISTANT: Dr. L. Reddy

2nd ASSISTANT: Dr. Rodriguez

ANESTHETIST: Dr. Yoon

ANESTHESIA: General

PREPARATION: E-Z prep

OPERATIVE FINDINGS: This 65 year old male who is a machine operator was admitted to our Emergency Room after being stabbed by another person. He had multiple lacerations of the left side of the face and of dorsum of left and right wrist. The lacerations of the right hand were two in number. The first one was quite an extensive, deep laceration over the dorsal region of the metacarpal phalangeal joint of the right index finger. The transverse laceration in that region measured approximately 5.5 cm. and it extended through the joint capsule, thus severing completely the dorsal hood extensor tendon mechanism of the right index finger at the MP joint level. Moreover, there was partial laceration of the extensor tendon hood of the right middle finger at the level of the metacarpal phalangeal joint.

Mamoun M.D.
DICTATED BY: Dr. Mamoun

ATTENDING PHYSICIAN: Dr. L. Reddy

TRANSCRIBED BY: C. Fennell

In addition, there was a second 2 cm. long laceration of the skin only over the proximal interphalangeal joint of the right ring finger. The lacerations over the left side of the face were located one over the inferior region of the ear lobule, and one on the left zygomatic region and each one of these measured approximately 1.3" in length. There was no nerve injury apparent in the left side of the face. Today, repair of the facial lacerations as well as suture repair of the severed extensor hood tendon mechanism of the right index finger (dorsally) was performed under general anesthesia.

PROCEDURE: Under general anesthesia and following preparation of the right hand and forearm with Betadine and proper draping and using tourniquet for ischemia, the procedure was started. The laceration over the dorsal metacarpal phalangeal region of the right index finger was explored and it was found that the most dorsal articular surface of the head of the metacarpal was involved in a chip fracture with loss of approximately 2 x 2 mm. of the latter surface. The MP joint in the region was completely exposed. The whole area was thoroughly irrigated with copious amounts of saline. There were few major vessels found in the area and these were tied with 4-0 plain catgut. While an assistant was maintaining the right index finger in complete extension, repair of the joint capsule dorsally was first started using a few interrupted sutures of 4-0 white Mersilene. The sutures were applied in a horizontal mattress type of suturing. Subsequently the extensor hood tendon mechanism of the right index finger was repaired using horizontal mattress sutures of 4-0 white Mersilene. In addition, a continuous running of 5-0 monofilament nylon was used in order to have final approximation of the tendon edges. Subsequently the skin edges were approximated with a few interrupted simple and vertical mattress sutures of 5-0 monofilament nylon. The partial laceration of the extensor hood of the middle finger was next repaired with a few interrupted horizontal mattress sutures of 4-0 white Mersilene. The skin laceration joint was next repaired with a few sutures of 5-0 nylon. A dressing was applied using Xeroform gauze over the suture lines in addition to a hand dressing, maintaining the right index and middle finger in extension at the metacarpal phalangeal joint. The wrist was also maintained in 15 degrees of extension using a Volar splint of Plaster of Paris. The left facial lacerations were repaired following preparation of the face with Aqueous Zephiran and proper draping using 4-0 chromic catgut for the deep layers and a few interrupted sutures of 6-0 nylon. Dressings were applied over the suture lines and the patient tolerated the procedure satisfactorily and was sent to the R.R. in a general good health.

Sami Mamoun M.D.
SAMI MAMOUN, M.D.



Case No. 6; fig. 1: Stab wound transverse laceration across the dorsal
of joint of the right index and middle fingers, with severed extensor
tendon mechanism and joint capsule of the index finger.



Case No. 6; Fig. 2: Operative view of the primary repair, demonstrating the separate closure of each of the severed joint capsules, and the extensor hood mechanism at the MP joint of the right index finger, while an assistant maintains the finger in extension.



Case No. 6; fig. 3: Operative view of the repaired extensor hood at the MP joint of the right index finger. The latter was maintained in extension by an assistant during the repair procedure.



Case No. 6; fig. 4: Operative view of the skin closure following primary repair of the severed extensor hood of the right index finger.



Case No. 6; fig. 5: The dressing applied; a volar splint maintained the index and middle fingers in extension at the MP joint.



Case No. 6; fig. 6: Lateral view of the patient's right hand three weeks post operatively.



Case No. 6; fig. 7: Dorsal view of the right hand three weeks post operatively, showing satisfactory wound healing.

7. Category Seven : Congenital anomalies .

Case No 7 :

Bilateral polydactyly of the little fingers.

Candidate's Name: Sami M. Mamoun, M.D.

Category Seven: Congenital Anomalies.

Case No. 7: Bilateral polydactyly of the little fingers.

This 8 year old spanish girl was brought to our clinic because of bilateral supernumerary digits. The duplicated digit in each hand was attached to the ulnar side of each little finger, and measured approximately one inch in length, with about the same width as that of the little finger. Moreover, each digit was attached by a narrow pedicle of skin. On the right side, it originated from the middle phalanx whereby on the left side it originated from both the proximal and middle phalanges of the little fingers (Fig. 1 & 2). There were no bony attachments in between the extra digits and the little fingers. Moreover the patient stated that she had minimal sensation in each of these extra digits, but she had normal sensation along the ulnar side of the little finger. X-rays of both hands (Fig. 3) revealed the presence of 3 separate poorly visualized rudimentary bones in each of the extra digits.

The family history of this patient revealed that she had three siblings (two females and one male), who had similar polydactyly. Moreover, her father and grandfather both had polydactyly. Two of her second cousins, on the mother's side had combination of syndactyly and/or polydactyly of fingers and/or toes.

This 8 year old girl was always self-conscious of the presence of these extra digits in each hand. Moreover she used to feel quite embarrassed at school to the extent that she would often cover her hands with bandage gauze or hide them in her pockets.

The plan on this patient was to excise these extra digits under local anesthesia. The girl was quiet and cooperative. So under general sedation and 1% xylocaine infiltration, the pedicles of the extra digits were outlined with methylene blue (Fig. 4) and the digits excised. There were no tendons or nerves grossly apparent within the pedicle. Following complete hemostasis the skin edges were approximated with No. 6.0 Nylon with no tension (Fig. 5) and patient tolerated the procedure well.

Her post-operative course was uncomplicated and she healed well. (Fig. 6) Subsequently her parents expressed their wishes to have similar procedures performed on their other children and some other involved member of their families sometime later on.

Sami Mamoun M.D.

OPERATIVE RECORD

660-2

5A

527395

LOCATION (OR ADDRESS)

UNIT NUMBER

Preoperative Diagnosis Complete
Congenital Supernumerary Digits
(Bilateral, Little Fingers)

Date 12/20/73

Doctor Lo Verme

Postoperative Diagnosis

CONDITION OF PATIENT

Same

Temperature	Respiration	Pulse	Blood Pressure	General Condition

Anesthetic Local Xylocaine 1% Plain

Condition during Anesthesia (Pulse, Respiration, Stimulants, etc.)

Surgeon Dr. Mamoun

Anesthetist Dr. Sullivan/Dr. Vea (Standby)

Assistants Dr. Lo Verme
Dr. Gianetti

Operation Excision of Supernumerary Digits
(Congenital) of Ulnar Side of each
of the Little Fingers, Both Hands

Began 8:20 A.M.-8:45 Closed 9:10

Instrument Nurse D. Battaglia, R.N.

Sponge Nurse V. De Vries, R.N.

Findings (Gross): Describe all Pathological Findings and All Organs Explored, Normal and Abnormal

This 8 y o Spanish girl was born with a congenital supernumerary digit projecting from the ulnar side of the middle phalanx of each of the little fingers of both hands. Each of the extra digits measured approximately 1" in length with a width approximating that of a normal finger. These digits were attached by a pedicle of skin with no bony attachment in between the little finger and the extra digit.

The patient stated that she had minimal sensation in each of these extra digits, but she had normal sensation of the ulnar side of the little finger. Moreover, three siblings (two females and one male) as well as the father and a few members of the families of both the mother and the father had similar congenital deformities. Some of the family members had syndactyly as stated by the parents. No other congenital deformities could be found.

It was decided, therefore, to excise the supernumerary digit from the little finger of each hand since the patient felt embarrassed at school and she used to wrap her hands up in order to hide the digit. Therefore, due to the development of these emotional problems, the family, as well as the patient herself decided to have these extra digits removed. This was performed today under local anesthesia.

OPERATIVE TECHNIQUE: Using 1% Xylocaine digital local infiltration and following preparation of both hands with Betadine and proper draping, the supernumerary extra digits were outlined in an elliptical pattern around their pedicle and they were excised. There was a major artery extending into each of the digits and each of these arteries had to be clamped and ligated with #4-0 chromic cat gut. We could not find any major nerve extending into each of these extra digits although, there was possibly a fine nerve filaments going through them. The skin edges were approximated easily with a few interrupted sutures of 6-0 nylon. Bleeders were controlled and dressings applied. Patient tolerated the procedure satisfactorily and was sent back to her room in good condition.

Immediate Postoperative Condition (Hemorrhage, Shock, etc.)

Dictated by: Dr. Mamoun

Signature of Operator Sami Mamoun M.D.

Transcriber: Mary Geremia

Date Dictated: 12/20/73

Date Typed: 1/15/74

(CONTINUE ON REVERSE SIDE)

JERSEY CITY MEDICAL CENTER

CHECK: ☐ WHEEL CHAIR ☐ O. R.
☐ AMBULATORY ☐ STRETCHER ☐ PORTABLE
 PREVIOUS X-RAYS AT J.C.M.C. ☐ NO ☐ YES-YEAR: ☐ BIRTHDATE: / / SEX: ☐

Do Not Write Here
TEMP. X-RAY NO.

TYPE PATIENT: ☐ IN-PAT. ☐ CLINIC ☐ EMERG. ☐ MED. ☐ SERVICE ☐ O.P. ☐ OTHER:

EXAMINATION REQUESTED:

☒ ROUTINE ☐ STAT

Chest X-ray & X-ray of
 CLINICAL DIAGNOSIS: both hands Right
 PERTINENT HISTORY: and left
 Supernumerary digits

CLINICAL DIAGNOSIS:

PERTINENT HISTORY:

PREPARED BY:

REQUESTED BY:

Dr. Mariani, M.D.

REMARKS:

TECH:

DATE DONE:

ROOM:

DO NOT WRITE BELOW THIS LINE

REPORT: 12/18/73

527395

CODE NO.

CHEST:

Routine views of the chest reveal the cardiopulmonary findings to be within normal limits.

IMPRESSION: Negative chest.

Dr. Amiri/jm

LEFT HAND:

Routine views of the left hand fail to demonstrate the presence of any fracture or dislocation.

Dr. Amiri/jm

RIGHT HAND:

Routine views of the right hand fail to demonstrate the presence of any fracture or dislocation.

Dr. Amiri/jm

58 070710-0
 527395
 FOR LOVERNE PLA 12-10-73

PRE-OP CHEST

FILMS USED

5x7	8x10	9x9	10x12	11x14	14x17	CINE	Dent.
	2			2			

CATALOG
NO 6022

MEDICAL CENTER - JERSEY CITY, N.J.

PATHOLOGY REPORT

S73-2805

LAST NAME

Dr. LoVerme

FIRST NAME

5 Med.

076716-0, 527395

LOCATION

UNIT NUMBER

Specimen No. S73-2805

Date 12/20/73

Operation Supernumery digits, small fingers

GROSS DESCRIPTION: Specimen designated as left and right supernumery fingers are received in formalin and consists of 2 pieces of amputated small digits, one measuring 1.8 x 1.2 x 0.7 cm. with 0.5 cm. nailbed. The other measures 1.3 x 1.2 x 0.7 cm. with 0.3 cm. nailbed, in bisection both show bone component.

2 Sections are taken.

N. David, M.D.

MICROSCOPIC DESCRIPTION: Sections reveal skin and bone without significant histological changes.

DIAGNOSIS:

SUPERNUMERY DIGITS, RIGHT AND LEFT HAND.
Y8-2231

R. Platt
R. Platt, M.D.

RP/mjy

12/28/73



Case No. 7; figs. 1 & 2: Preoperative dorsal and volar views of both hands with bilateral polydactyly of the little fingers.



Case No. 7; fig. 3: Preoperative x-rays of both hands, showing the presence of three separate poorly visualized rudimentary bony phalanges in each of the extra digits.



Case No. 7; fig. 4: Operative view of one extra digit, showing the excisional outline of its pedicle.



Case No. 7; figs. 5 & 6: Post operative appearance of the little fingers and of both hands, three weeks following excision of the extra digits.

8. Category Eight : Complications : Iatrogenic or unexpected .

Case No. 8 :

Wound dehiscence and necrosis following abdominal lipectomy
for excessive adiposities .

Case Summary

Candidate's Name: Sami M. Mamoun, M.D.

Category Eight: Complications: Iatrogenic or Unexpected

Case No. 8: C. ...
Wound Dehiscence and Necrosis Following Abdominal Lipectomy for Excessive Adiposities

This 53 year old white female housewife was admitted complaining of excessive redundancy of the abdominal wall with adipose accumulation (Fig. 1 & 2). She weighed about 300 lbs on admission. A few years earlier, she had weighed 400 lbs. Moreover, she was a known chronic diabetic, whose condition could not always be controlled with diet and oral medication. She also gave history of previous pregnancies and one abdominal operation for umbilical herniation. Examination revealed generalized obesity, striae, with diastasis recti, and a mild degree of ventral herniation on straining. She also had a transverse supra-umbilical surgical scar from a previous operation. Her breasts were markedly hypertrophied and ptotic. She also had severe redundancy of skin and adipose tissue around the upper and lower extremities.

The patient gave several reasons for requesting our assistance. Among them was the fact that the excessive abdominal redundancy was greatly restricting her walking, in addition to its unaesthetic appearance. Moreover, she specifically complained of the difficulty she was having in preventing the occurrence of inter-trigo and skin maceration due to excessive sweating inbetween the redundant abdominal panniculus and the underlying skin surfaces. She desired to have the redundant abdominal skin and fat excised. Because her umbilicus was severely displaced and deformed, she requested that no special effort be made to reconstruct it. We acted accordingly.

Following control of her diabetes, the surgical reduction of her abdomen was performed under general anaesthesia. A transverse incisional line was drawn along the superior limit of the pubic hairline, crossing the inguinal regions and continuing slightly further laterally along the thighs. The abdominal skin flap was next undermined along the supra-aponeurotic plane until the costal margins (Fig. 3). Subsequently, the muscular diastasis was corrected by reinforcement of the musculoaponeurotic wall. The redundant abdominal skin was excised along both the transverse and vertical planes. The excised tissue weighed about 16 lbs (Fig. 4). Next, the wounds were closed in layers, using Hemovac suction drainage.

Her post operative course was complicated by wound dehiscence and necrosis in the midline vertical plane (Fig. 5). Culture of the discharge revealed pseudomonas and proteus organisms. The patient was put on antibiotics and frequent change of dressings. Her diabetes was very difficult to control. Gradually, the wound discharge diminished, and wound margins contracted. Her hospital stay was about six weeks. After discharge, arrangements were made for followup in our clinic, as well as daily wound care at home by a visiting nurse. About ten weeks post-operatively, the wound was completely closed.

Figs. 6, 7 and 8 show the patient five months post operatively. She was satisfied with the operative results, and walking around more comfortably than before.

Sami M. Mamoun M.D.

OPERATIVE RECORD

660-2

16 Medical

416667

LOCATION (OR ADDRESS)

UNIT NUMBER

Preoperative Diagnosis Complete

Diastasis Recti, Ventral Hernia,
Panniculosis Adiposis

CONDITION OF PATIENT

Temperature	Respiration	Pulse	Blood Pressure	General Condition

Anesthetic General

Condition during Anesthesia (Pulse, Respiration, Stimulants, etc.)

Operation See Below

Began 11:50 a.m. Closed 4:00 p.m.

Date 9/10/73

Doctor Rhodes

Postoperative Diagnosis

Same

Surgeon Dr. Mamoun

Anesthetist Dr. Baron/Dr. Overall

Assistants Dr. Gianetti/Dr. Rhodes
Dr. Mastromonaco

Instrument Nurse Norton/Boyle/Ykenhoff

Sponge Nurse DiCiancia/Marchese/Tuzinkiev

Operation:

1. Repair of Diastasis Recti.
2. Ventral Herniorrhaphy.
3. Abdominal Lipectomy.

Findings:

This 53 y.o. W/F came to the Clinic complaining of extensive redundancy of the abdominal skin and fat in addition to a ventral hernia in the midline region. Moreover, she had diastasis recti that one could feel. The patient also was complaining of irritation in the fold underneath the extensive redundancy of the lower abdomen. The patient previously weighed approximately 400 pounds and during the past five she reduced her weight down to approximately 300 pounds, thus losing about 100 pounds, resulting in severe redundancy of the lower abdominal skin and fat. Moreover, the patient had chronic diabetes. Today repair of the diastasis recti in addition to the ventral herniorrhaphy was performed. Abdominal lipectomy was carried out and the total of 16 pounds of skin and fat was excised. Excision of the tissue was performed along the transverse plane as well as along the vertical plane.

Procedure:

Under general anesthesia with the patient in supine position and following preparation of the abdomen with Betadine and proper draping, a transverse incisional line was drawn extending transversely along the pubic hair line and the incisional line was extended laterally towards the upper region of the inguinal ligament and across the upper region of the thigh anteriorly on either side. It was decided (the patient's request) not to

Immediate Postoperative Condition (Hemorrhage, Shock, etc.)

Dictated by: Dr. Mamoun

Signature of Operator

Sami Mamoun

M.D.

Transcriber: Karen Miller

Date Dictated: 9/10/73

Date Typed: 9/20/73

(CONTINUE ON REVERSE SIDE)

preserve the umbilicus since the later was already pulled down and displaced markedly off its normal place. Moreover, the patient had an umbilical herniorrhaphy procedure performed many years ago and the umbilical region was quite deformed. For the later reasons it was decided not to reconstruct the umbilicus since the patient did not desire such a procedure. After the incision was made, the later was extended down through the subcutaneous tissue, superficial fascia and extended down to the deep fascia over the external rectus sheath and external oblique fascia. The redundant panniculosis was dissected off the deep rectus and external oblique fascia and dissection was carried superiorly elevating the panniculus up to the region of the xiphoid and the inferior costal margins bilaterally. Dissection was facilitated by making a vertical incision through the panniculus in the midline for a distance of approximately 5 to 6". All major bleeders were ligated with #3-0 chromic catgut and the other bleeding points were controlled by electrocoagulation. Following the dissection and elevation of the abdominal flap, the operating table was slightly flexed, about 20° and the abdominal flap was advanced inferiorly on top of the inferior skin flap and the excess skin and fat were outlined transversely and excised. The maximum width of the margin of the skin excised along the inferior margin of the abdominal flap measured approximately 10". Subsequently, the vertical portion of the skin to be excised from the midline region of the flap was next outlined with Methylene blue in an inverted V pattern with the vertex of the V extending from the xiphoid region. The width of the vertical portion of the skin and fat to be excised was measured by approximating the medial region of the abdominal flap and determining the excess of skin and fat available. Following excision of the vertical segment of excess tissue, attention was focused on repairing the diastasis recti and the ventral herniorrhaphy. The later was performed by applying interrupted vertical mattress sutures of #3-0 Mersilene in the rectus fascia imbricating the midline region of the fascia starting from the xiphoid superiorly down to the suprapubic region. Following this procedure, we had satisfactory repair of the weakened abdominal surface. The maximum width of the vertically excised segment measured approximately 7". The flaps were next approximated and advanced together and the fat layer was approximated with interrupted sutures of 4-0 and 3-0 chromic catgut and following the insertion of two large Penrose drains on either side the deep dermal layers were approximated with interrupted sutures of 3-0 and 4-0 chromic catgut and the skin edges were approximated with continuous and a few interrupted sutures of 4-0 and 5-0 nylon. The vertical segment of the skin incision was approximated with continuous subcuticular sutures of #5-0 nylon pull-out. Subsequently, steri-strips were applied for further reinforcement of the skin edges and Xeroform gauze was applied along the incisional suture line. Fluffs of gauze were then applied over the abdomen re-enforced by abdominal gauze pads and elastoplast adhesive tape. In addition, a layer of plaster splint of plaster of paris was applied on the abdomen in order to maintain even pressure on the abdomen to prevent possible formation of hematoma collection. The patient tolerated the procedure satisfactorily and she was sent to the R.R. with the endotracheal tube in place, which was later removed when the patient was fully conscious and awake. A nasogastric tube was previously inserted to deflate the patient's stomach. Moreover, a Foley catheter was inserted just prior to surgery. The patient tolerated the procedure well.

Solmi Mamoun M.D.

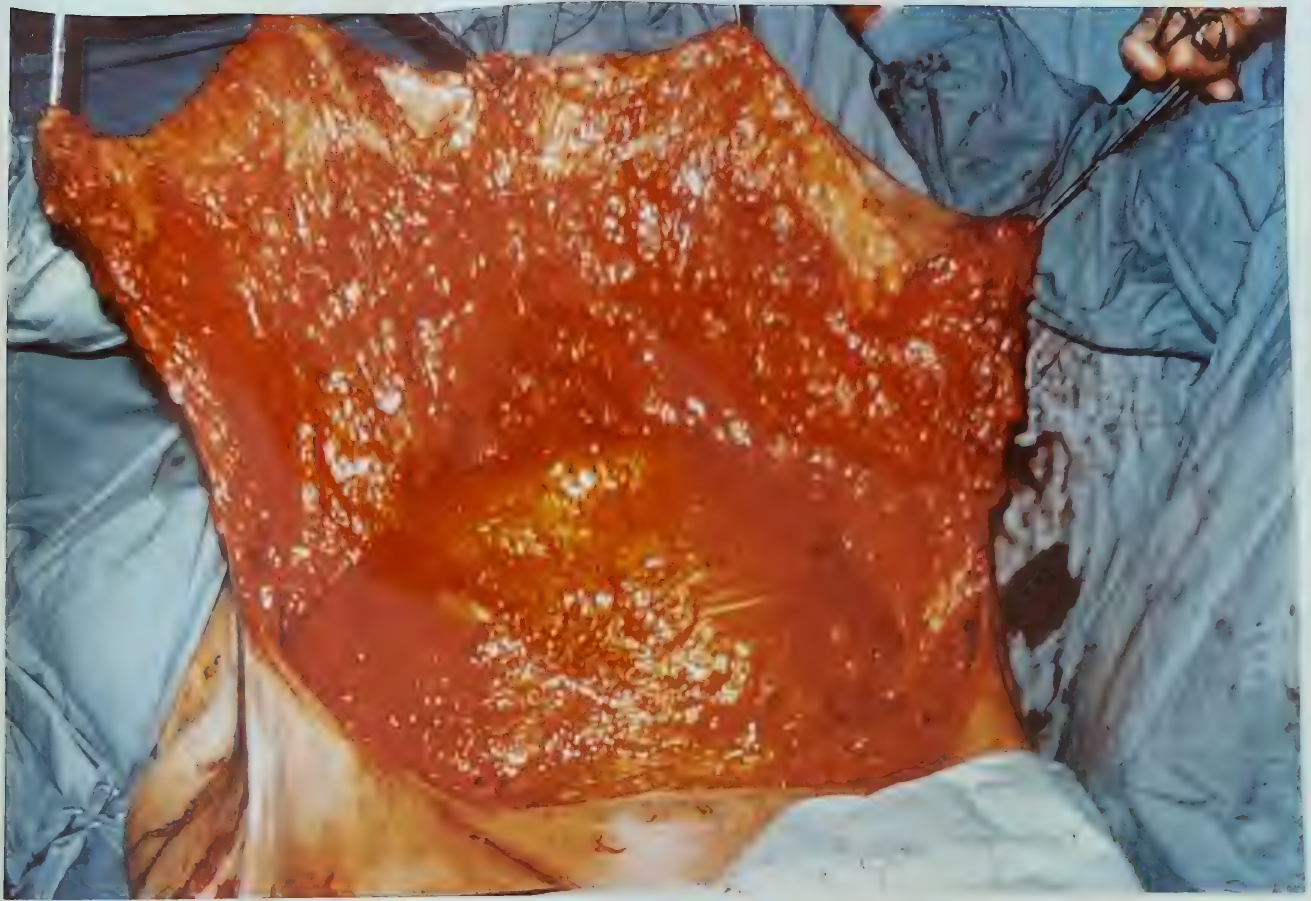
Dr. Mamoun



Case No. 8; fig. 1: Preoperative front body view of the patient, showing the generalized excessive adiposities with the redundant abdominal panniculus.



Case No. 8; fig. 2: Preoperative lateral view of the 300 lb patient, who was a known poorly controlled chronic diabetic.



Case No. 8; fig. 3: The excessive abdominal panniculus undermined and elevated off the aponeurotic plane, to the level of the coastal margins.



Case No. 8; fig. 4: The redundant abdominal panniculus specimen excised from the vertical and transverse planes. The combined weight of all specimens was 16 lb.



Case No. 8; fig. 5: Post operative wound dehiscence and fat necrosis in the midline vertical plane. Patient also had skin sensitivity reactions to the Steri Strip adhesive tape.



Case No. 8; fig. 6: Five months post operative front view, showing complete wound closure and satisfactory healing.



Case No. 8; fig. 7: Five months post operative lateral view of the patient.



Case No. 8; fig. 8: Closeup view of the abdominal healing scars five months post operatively, showing satisfactory results.